MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Type of Requestor: (x) HCP ( ) IE ( ) IC	**Response Timely Filed?** (x) Yes () No
Requestor's Name and Address Dr. S, MD 431 Omega Drive, Suite 104 Arlington, Texas 76014	MDR Tracking No.: M4-03-8912-01 TWCC No.: ___ Injured Employee's Name: ___
Respondent's Name and Address State Office of Risk Management Box 45	Date of Injury: ___ Employer's Name: ___ Insurance Carrier's No.: WC2098820

PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
04/22/03	04/22/03	99214	$71.00	$0.00

PART III: REQUESTOR'S POSITION SUMMARY

Requestor states in their position statement, "We contend that the documentation clearly supports the level billed."

PART IV: RESPONDENT'S POSITION SUMMARY

Carrier's response states, "CPT code 99214 requires at least two key components out of three: a detailed history; a detailed examination; medical decision making of moderate complexity. Therefore, the Office will maintain our denial of insufficient documentation based on the Act and Rules." Carrier denied services as, "Upon review, documentation as submitted does support the level of service(s) billed. Reimbursement based on level of service documented."

PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

Documentation submitted by the requestor does not meet the criteria per rule 133.1 (E)(i). The documentation is not legible and does not contain at least two of the three components required per the above mentioned rule.

Therefore, based on this information reimbursement is not recommended.

PART VI: DETAIL FINDINGS (If needed)

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
				Total Left Column:			$0.00
				Total Amount Due:			$0.00

PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is not entitled to reimbursement.

Ordered by:

Authorized Signature	Michael Bucklin	12/27/04
	Typed Name	Date of Order

PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.

PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: _____ Date: _____